SERFF Tracking Number:	*AMFD-126742830*	*State:*	*Arkansas*
Filing Company:	*Sagicor Life Insurance Company*	*State Tracking Number:*	*46407*
Company Tracking Number:	*5033, 5034*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life Applications*		
Project Name/Number:	*/5033, 5034*		

Filing at a Glance

Company: Sagicor Life Insurance Company

Product Name: Life Applications	SERFF Tr Num: AMFD-126742830	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 46407
Sub-TOI: L08.000 Life - Other	Co Tr Num: 5033, 5034	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Francine Cardon	Disposition Date: 08/10/2010
	Date Submitted: 08/05/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Authorized
Project Number: 5033, 5034	Date Approved in Domicile: 07/15/2010
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 08/10/2010	Explanation for Other Group Market Type:
	State Status Changed: 08/10/2010
Deemer Date:	Created By: Francine Cardon
Submitted By: Barbara Lathrop	Corresponding Filing Tracking Number:

Filing Description:

RE: Sagicor Life Insurance Company
NAIC No.: 60445; FEIN: 74-1915841
Form Nos.: 5033 Individual Life Insurance Application
5034 Individual Life Insurance Simplified Issue Application
5032 Fixed Indexed Supplemental Application
5035 Application Amendment
5070 Foreign Travel & Residence Questionnaire
5071 Aviation Questionnaire
5073 Financial Questionnaire – Personal

SERFF Tracking Number:	*AMFD-126742830*	*State:*	*Arkansas*
Filing Company:	*Sagicor Life Insurance Company*	*State Tracking Number:*	*46407*
Company Tracking Number:	*5033, 5034*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life Applications*		
Project Name/Number:	*/5033, 5034*		

5074 Financial Questionnaire – Business
5075 Alcohol/Drug Questionnaire
5076 Avocation Questionnaire
Statement of Variability
Flesch Certification

The above referenced forms are submitted for your review and approval. No part of this filing contains any unusual or possibly controversial items from normal company or industry standards. These documents are final printed versions. Applications 5033, 5034, and 5035 will be used with our Term Life, Whole Life and Universal Life products. Application Amendment form 5035 will be used with all life products to correct information provided on the original application, such as premium paid, social security number and address but will not change policy provisions. Application 5032 will be used with our fixed indexed Whole Life, Universal Life and Annuity products. This form will be used by the applicant to choose their initial and renewal allocations. We are also enclosing six Questionnaires for approval.

Application 5033 replaces form 5004 approved 12/06/06 under SERFF Tracking Number AMFD-125039278 and form 5026 approved 07/15/08 under SERFF Tracking Number AMFD-125698490. Applications 5033 and 5034 replace form 5024 approved 02/29/08 under SERFF Tracking number AMFD-125443275.

Application 5032 replaces form 5018 approved 06/19/08 under SERFF Tracking Number WESA-125356788 and form 5013 approved 06/25/07 under SERFF Tracking Number AMFD-125146616.

Application 5035 replaces form 5002 approved 12/06/06 under SERFF Tracking Number AMFD-125039278.

Questionnaire 5070 replaces form 7004 approved 12/06/06 under SERFF Tracking Number AMFD-125039278.

Questionnaire 5071 replaces form 5019, 5076 replaces form 5020, 5073 replaces form 5021, 5074 replaces form 5022 and 5075 replaces form 5023. The Questionnaires being replaced were approved on 02/29/08 under SERFF Tracking Number AMFD-125443275.

A Flesch Certification and Statement of Variability are included with this submission.
Please note that Sagicor may change the appearance and pagination but not the text of these forms to comply with future changes in print systems. No font will be less than a 10 point font size. The color and/or weight of the paper on which these forms are printed may change. No changes to the text other than correction of typographical errors will be made to the forms without re-filing them with you.
If you need additional information, please do not hesitate to contact me at Francine_Cardon@sagicor.com or at 888-724-4267, extension 5652. Thank you for your consideration.
Sincerely,
Francine Cardon

SERFF Tracking Number:	*AMFD-126742830*	*State:*	*Arkansas*
Filing Company:	*Sagicor Life Insurance Company*	*State Tracking Number:*	*46407*
Company Tracking Number:	*5033, 5034*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life Applications*		
Project Name/Number:	*/5033, 5034*		

Contract Analyst

Company and Contact

Filing Contact Information

Francine Cardon, Compliance Analyst
4343 N. Scottsdale Road
Suite 300
Scottsdale, AZ 85251

Francine_Cardon@sagicor.com
480-425-5100 [Phone]
480-425-5150 [FAX]

Filing Company Information

Sagicor Life Insurance Company
4343 N. Scottsdale Road
Suite 300
Scottsdale, AZ 85251
(800) 531-5067 ext. 5653[Phone]

CoCode: 60445
Group Code: 3766
Group Name:
FEIN Number: 74-1915841

State of Domicile: Texas
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$500.00
Retaliatory?	No
Fee Explanation:	$50 x 10 forms
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Sagicor Life Insurance Company	$500.00	08/05/2010	38555563

SERFF Tracking Number:	*AMFD-126742830*	*State:*	*Arkansas*
Filing Company:	*Sagicor Life Insurance Company*	*State Tracking Number:*	*46407*
Company Tracking Number:	*5033, 5034*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life Applications*		
Project Name/Number:	*/5033, 5034*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/10/2010	08/10/2010

SERFF Tracking Number:	*AMFD-126742830*	*State:*	*Arkansas*
Filing Company:	*Sagicor Life Insurance Company*	*State Tracking Number:*	*46407*
Company Tracking Number:	*5033, 5034*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life Applications*		
Project Name/Number:	*/5033, 5034*		

Disposition

Disposition Date: 08/10/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMFD-126742830*	*State:*	*Arkansas*
Filing Company:	*Sagicor Life Insurance Company*	*State Tracking Number:*	*46407*
Company Tracking Number:	*5033, 5034*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life Applications*		
Project Name/Number:	*/5033, 5034*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variability		Yes
Form	Life Insurance Application		Yes
Form	Life Insurance Simplified Issue Application		Yes
Form	Application Amendment		Yes
Form	Fixed Indexed Supplemental Application		Yes
Form	Foreign Travel and Residence Questionnaire		Yes
Form	Aviation Questionnaire		Yes
Form	Avocation Questionnaire		Yes
Form	Financial Questionnaire (Personal)		Yes
Form	Financial Questionnaire (Business)		Yes
Form	Alcohol/Drug Questionnaire		Yes

SERFF Tracking Number:	*AMFD-126742830*	*State:*	*Arkansas*
Filing Company:	*Sagicor Life Insurance Company*	*State Tracking Number:*	*46407*
Company Tracking Number:	*5033, 5034*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life Applications*		
Project Name/Number:	*/5033, 5034*		

Form Schedule

Lead Form Number: 5033

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	5033	Application/ Enrollment Form	Life Insurance Application	Initial		51.400	5033 FULL UNDERWRITING - File Copy 7.15.10.pdf
	5034	Application/ Enrollment Form	Life Insurance Simplified Issue Application	Initial		50.500	5034 SIMPLIFIED ISSUE - File Copy 7.15.10.pdf
	5035	Application/ Enrollment Form	Application Amendment	Initial		56.600	5035 Amendment App - File Copy 07.15.10.pdf
	5032	Application/ Enrollment Form	Fixed Indexed Supplemental Application	Initial		53.100	5032 Fixed Indexed Supp App - File Copy 07.07.2010.pdf
	5070	Application/ Enrollment Form	Foreign Travel and Residence Questionnaire	Initial		57.500	5070 Foreign Travel and Residence Questionnaire - File Copy 07.2010.pdf
	5071	Application/ Enrollment Form	Aviation Questionnaire	Initial		59.400	5071 Aviation Questionnaire - File Copy 07.2010.pdf

SERFF Tracking Number:	*AMFD-126742830*	*State:*	*Arkansas*
Filing Company:	*Sagicor Life Insurance Company*	*State Tracking Number:*	*46407*
Company Tracking Number:	*5033, 5034*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life Applications*		
Project Name/Number:	*/5033, 5034*		

5076	Application/ Enrollment Form	Avocation Questionnaire	Initial	51.000	5076 Avocation Questionnaire - File Copy 7-15-10.pdf
5073	Application/ Enrollment Form	Financial Questionnaire (Personal)	Initial	67.300	5073 Financial Questionnaire Personal - File Copy 07.2010.pdf
5074	Application/ Enrollment Form	Financial Questionnaire (Business)	Initial	58.100	5074 Financial Questionnaire Business - File Copy 07.2010.pdf
5075	Application/ Enrollment Form	Alcohol/Drug Questionnaire	Initial	50.300	5075 Alcohol Drug Questionnaire - File Copy 07.2010.pdf

Sagicor

LIFE INSURANCE COMPANY

INDIVIDUAL LIFE INSURANCE APPLICATION

SECTION 1 – Proposed Insured Information

Name: _____ Sex: ☐ Male ☐ Female
(First) (MI) (Last)

Street Address: _____
City State ZIP Code

Former Address: _____
(If at current address less than 2 years) City State ZIP Code

Telephone No. : Home _____ Work _____ Other _____

Social Security Number: _____ Driver's License Number/State: _____

E-Mail Address: _____ Marital Status: _____

Date of Birth: _____ Place of Birth: _____ Height: _____ Weight: _____

Employer's Name: _____ Occupation: _____ Annual Earned Income: $ _____

Is the Proposed Insured a U.S. Citizen? ☐ Yes ☐ No Alien Registration Number: _____

*(If **NO**, please complete a Foreign Travel & Residence Questionnaire and provide an Alien Registration Number.)*

SECTION 2 – Additional Proposed Insured Information

(If there are Additional Proposed Insureds, please attach information on a separate sheet of paper.)

Name: _____ Sex: ☐ Male ☐ Female
(First) (MI) (Last)

Street Address: _____
City State ZIP Code

Former Address: _____
(If at current address less than 2 years) City State ZIP Code

Telephone No. : Home _____ Work _____ Other _____

Social Security Number: _____ Driver's License Number/State: _____

E-Mail Address: _____ Marital Status: _____

Date of Birth: _____ Place of Birth: _____ Height: _____ Weight: _____

Employer's Name: _____ Occupation: _____ Annual Earned Income: $ _____

Is the Additional Proposed Insured a U.S. Citizen? ☐ Yes ☐ No Alien Registration Number: _____

*(If **NO**, please complete a Foreign Travel & Residence Questionnaire and provide an Alien Registration Number.)*

SECTION 3 – Proposed Owner Information

(If it is different from the Proposed Insured. If this is a Trust, please provide a copy of the Title and Signature page.)

Name: _____ Date of Birth/Trust Date: _____

(First) (MI) (Last)

Street Address: _____ SSN/Tax ID #: _____

City State ZIP Code

Telephone No. : Home _____ Work _____ Other _____

E-Mail Address: _____ Driver's License Number/State: _____

Is the Proposed Owner a U.S. Citizen? ☐ Yes ☐ No Alien Registration Number: _____

*(If **NO**, please complete a Foreign Travel & Residence Questionnaire and provide an Alien Registration Number.)*

SECTION 4 – Beneficiary Information *(If there are Additional Beneficiaries, attach information on a separate sheet of paper.)*

Primary Beneficiary Name: _____ Relationship: _____

Street Address: _____

City State ZIP Code

Social Security Number/Tax ID: _____ Date of Birth/Trust Date: _____

Is the Primary Beneficiary a U.S. Citizen? ☐ Yes ☐ No Alien Registration Number: _____

*(If **NO**, please complete a Foreign Travel & Residence Questionnaire and provide an Alien Registration Number.)*

Contingent Beneficiary Name: _____ Relationship: _____

Street Address: _____

City State ZIP Code

Social Security Number/Tax ID: _____ Date of Birth/Trust Date: _____

Is the Contingent Beneficiary a U.S. Citizen? ☐ Yes ☐ No Alien Registration Number: _____

*(If **NO**, please complete a Foreign Travel & Residence Questionnaire and provide an Alien Registration Number.)*

SECTION 5 – Select Coverage

Face Amount Applied For: $ _____

Platinum Series Products

[☐ Fixed Indexed Universal Life]

[☐ No Lapse Universal Life (over $75,000)]

[☐ 10 Year ☐ 20 Year ☐ 30 Year Term Life]

Gold Series Products

[☐ Whole Life (over $75,000)]

[☐ Other Gold or Platinum Series Plan Not Listed] _____

<u>Not all of the riders are available for all products in all states</u>

Optional Riders Applied For:

[☐ Accidental Death Benefit] $ _____

[☐ Accident Disability Income Benefit] $ _____

[☐ Additional Insured Term] $ _____

[☐ Primary Insured Term] $ _____

[☐ Children's Term (Complete Children's Term Rider Application and attach)]

[☐ Waiver of Premium] [☐ Waiver of Monthly Deductions] [☐ Guaranteed Insurability Option]

Automatic Premium Loan Option (select one) [☐ Yes ☐ No] [(Whole Life Only)]

Universal Life Elections (select one)

Guideline Premium Test ☐

Cash Value Accumulation Test ☐

Death Benefit Option (select one)

[☐ A] [☐ B]

SECTION 6 – Premium Information

Do you intend to finance the premium for this policy? ☐ Yes ☐ No

Premium Class Quoted: _____ (Policy will be issued in the premium class quoted unless advised otherwise.)

Premium Collected with Application: $ _____ Transfer/1035 Exchange: ☐ Yes ☐ No Amount: $ _____

Billing Method: ☐ Individual ☐ List/Group Bill

Planned Modal Premium: $ _____ Draft Initial Premium: ☐ Yes ☐ No

Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly EFT (*Complete an Electronic Funds Transfer (EFT) Authorization)*

SECTION 7 – Payor Information

(If different from the Proposed Owner. If this is a Trust, please provide a copy of the Title and Signature page.)

Name: _____ Date of Birth/Trust Date: _____

(First) (MI) (Last)

Street Address: _____ SSN/Tax ID #: _____

City State ZIP Code

Telephone No. : Home _____ Work _____ Other _____

E-Mail Address: _____ Driver's License Number/State: _____

Is the Payor a U.S. Citizen? ☐ Yes ☐ No Alien Registration Number: _____

*(If **NO**, please complete a Foreign Travel & Residence Questionnaire & provide an Alien Registration Number.)*

Relationship to the Proposed Owner(s)/Proposed Insured(s): _____

NOTICE: State insurance law may prohibit the owner of a life insurance policy from entering into an agreement to sell, transfer, or assign a life insurance policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued. You should consult with legal advisors if you have any questions about these matters.

SECTION 8 – In Force/Replacement Information

1. Will any life insurance or annuity in this or any other company be replaced or changed as a result of this application? *(If **YES**, please list the policy or contract below & complete a Replacement Form.)* ☐ Yes ☐ No
2. Does the Proposed Insured(s) or any Proposed Additional Insured(s):
   a) Have any other life insurance or annuity in force? ☐ Yes ☐ No
   b) Have any application (including reinstatement) for life insurance or annuity now pending? ☐ Yes ☐ No
3. Has the Proposed Insured(s) or any Proposed Additional Insured(s) applied for any life insurance or annuity in the last ninety (90) days? ☐ Yes ☐ No
   *(If **YES**, please list the policy or contract below.)*

Proposed Insured/Additional Insured	Company	Policy #	Amount	Issue Date	Plan Type

SECTION 9 – Health and Medical Questions

	Proposed Insured	Proposed Additional Insured
1. Do you currently require oxygen therapy or kidney dialysis? Have you been told that you need an organ transplant?	☐ Yes ☐ No	☐ Yes ☐ No
2. Do you require assistance to perform any 2 of 6 Activities of Daily Living (ADL's)? (ADL's are: eating, toileting, transferring, bathing, dressing, and continence.) Are you currently in a nursing home?	☐ Yes ☐ No	☐ Yes ☐ No
3. Have you tested positive for Human Immunodeficiency Virus (HIV); or been medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS); or been medically diagnosed as having AIDS Related Complex (ARC)?	☐ Yes ☐ No	☐ Yes ☐ No
4. Have you ever been diagnosed as having or treated by a physician for:		
a) epilepsy, convulsions, headaches, emotional or mental conditions, or any other disease or disorder of the brain or nervous system?	☐ Yes ☐ No	☐ Yes ☐ No
b) ulcers, colitis, hepatitis, or any other disease or disorder of the liver, gallbladder, pancreas, stomach, rectum, or intestines?	☐ Yes ☐ No	☐ Yes ☐ No
c) diabetes, high or low blood sugar, thyroid, lymphatic system, or any other glandular disease or disorder?	☐ Yes ☐ No	☐ Yes ☐ No
d) high cholesterol, anemia, or any other disease or disorder of the blood?	☐ Yes ☐ No	☐ Yes ☐ No
e) asthma, emphysema, tuberculosis or any other disease or disorder of the lungs or respiratory system, or sleep apnea?	☐ Yes ☐ No	☐ Yes ☐ No
f) arthritis, gout, severe injury or other disease or disorder of the spine, bones, joints, or muscles?	☐ Yes ☐ No	☐ Yes ☐ No
g) allergies or any other disease or disorder of the eyes, ears, nose, throat, or skin?	☐ Yes ☐ No	☐ Yes ☐ No
h) sugar, albumin or blood in the urine, kidney stones, sexually transmitted disease, or any other disease or disorder of the kidneys, bladder, urinary, or reproductive system?	☐ Yes ☐ No	☐ Yes ☐ No
i) high blood pressure, chest pains, heart attack or failure, or any other disease or disorder of heart or blood vessels, or irregular heart beat?	☐ Yes ☐ No	☐ Yes ☐ No
j) memory loss, dementia or Alzheimer's disease?	☐ Yes ☐ No	☐ Yes ☐ No
k) cancer, tumor, leukemia, melanoma, or any other abnormal or malignant growth?	☐ Yes ☐ No	☐ Yes ☐ No
5. Have you experienced any unexplained weight loss or gain over the last year?	☐ Yes ☐ No	☐ Yes ☐ No
6. In the last **10 years**, have you received advice, treatment, or been convicted for the use of alcohol? In the last **10 years**, have you used, received advice for, been treated for, or been convicted of the use or possession of any narcotic, stimulant, sedative, or hallucinogenic drug?	☐ Yes ☐ No	☐ Yes ☐ No
7. Other than as previously stated on this application, have you consulted or been examined or treated by any physician or other medical professional, or had observation or treatment at a hospital?	☐ Yes ☐ No	☐ Yes ☐ No
8. Have you had a natural parent or sibling diagnosed with coronary artery disease, heart attack, stroke, diabetes, cancer, or chronic kidney disease before age 60?	☐ Yes ☐ No	☐ Yes ☐ No
9. Have you had any laboratory tests, treatments, or diagnostic procedures (including x-rays, EKG's, or scans)?	☐ Yes ☐ No	☐ Yes ☐ No
10. In the last **5 years**, have you received or applied for disability sickness or injury benefits or use a walker or wheelchair?	☐ Yes ☐ No	☐ Yes ☐ No
11. In the last **5 years**, have you been confined to any hospital or clinic, or been advised by a physician to have any diagnostic tests, treatments, or surgery that is not completed?	☐ Yes ☐ No	☐ Yes ☐ No
12. Are you presently taking any prescribed medication or on a prescribed diet?	☐ Yes ☐ No	☐ Yes ☐ No

If you answered **YES** to any of these questions, please explain in the provided following space.

Question #	Proposed Insured(s) Name	Doctor's Name, Address & Phone Number	Date & Explanation

Proposed Insured(s) Name	Medication	Reason for Medication

Use for Additional Explanation Details

SECTION 10 – Personal History and Lifestyle Related Questions

	Proposed Insured	Proposed Additional Insured
1. In the last **<u>24 months</u>**, have you participated in: sky diving, scuba or skin diving, vehicle or motorcycle racing, rodeo activities, hang gliding, bungee jumping, or ballooning? *(If you answered **YES**, please complete an Avocation Questionnaire.)*	☐ Yes ☐ No	☐ Yes ☐ No
2. In the last **<u>10 years</u>**, have you had a driver's license suspended or revoked, have you been convicted of reckless or negligent driving or driving under the influence of alcohol or drugs? *(If you answered **YES**, please complete a Drug & Alcohol Questionnaire.)*	☐ Yes ☐ No	☐ Yes ☐ No
3. Have you used any form of tobacco or nicotine products including cigarettes, cigars, pipes, chewing tobacco, snuff, nicotine patches or gum in the last ☐ 2 ☐ 3 ☐ 5 years?	☐ Yes ☐ No	☐ Yes ☐ No
4. In the last **<u>5 years</u>**, have you been convicted of, or are you awaiting trial for a felony?	☐ Yes ☐ No	☐ Yes ☐ No
5. Has any Proposed Insured ever flown or intend to fly as a pilot or crew member of any aircraft other than a commercial airline? *(If you answered **YES**, please complete an Aviation Questionnaire.)*	☐ Yes ☐ No	☐ Yes ☐ No
6. Have you ever had an application for insurance or reinstatement of insurance declined, postponed, rated, or modified?	☐ Yes ☐ No	☐ Yes ☐ No
7. In the next **<u>2 years,</u>** do you intend to travel outside of the United States? *(If you answered **YES**, please complete a Foreign Travel & Residence Questionnaire.)*	☐ Yes ☐ No	☐ Yes ☐ No

SECTION 11 – Additional Information/Special Request or Instructions

SECTION 12 – Fraud Warning

District of Columbia, Alabama, Arizona, Arkansas, California, Delaware, Illinois, Montana, Nevada, North Dakota, South Dakota: Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Florida Residents Only: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false , incomplete or misleading information is guilty of a felony of the third degree.

New Jersey Residents Only: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Oregon Residents Only: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

SECTION 13 – Authorization and Acknowledgement

I understand that I am applying for life insurance coverage issued by Sagicor Life Insurance Company ("Sagicor"). I understand and consent that this application, and information obtained pursuant to this authorization may be used by Sagicor to evaluate my eligibility for life insurance.

I authorize the release to Sagicor of all information requested about me or any of my minor children proposed to be insured. This information may be released to Sagicor's authorized representatives. Authorized representatives include any consumer reporting agency acting on their behalf. Each of the following may be a source of information: the Medical Information Bureau, Inc. ("MIB"); my employer; physician, medical practitioner, hospital, clinic, or medically related facility; insurance or reinsuring company; consumer reporting agency; any other organization or insurance support organization; and a Pharmacy Benefit Manager.

Information means facts about me or any of my minor children that are proposed to be insured. Those facts include, but are not limited to; information about mental or physical health; other insurance coverage; use of drugs or alcohol; motor vehicle records; avocations; employment; prescription drug records; hazardous activities; character; general reputation; mode of living; finances; vocation; and other personal traits.

I understand and agree that Sagicor may disclose all or some of my information to its insurance administrators, its reinsurance companies, the producer who solicited my application and his or her principals, the MIB, and other persons or organizations performing business or legal services in connection with my application.

This authorization shall be valid for 30 months. I understand that I or my authorized representative may receive a copy of the authorization upon request. I agree that a photographic copy of this authorization shall be as valid as the original. I understand that I may revoke this authorization at any time by sending written notice to Sagicor's home office. I understand that my right to revoke this authorization is limited to the extent that Sagicor has not already taken action in reliance on the authorization.

To the best of my knowledge and belief, the statements and answers given on this form are true, complete, and correctly recorded. I understand that a policy does not go into effect and no liability exists for Sagicor until the policy is delivered and accepted by the Owner(s), the first full premium is paid, and there has been no change in the health of the Proposed Insured(s) that would change any of the answers in this application. I understand and agree that no producer may accept risks or pass upon insurability, make or modify contracts, or waive any of Sagicor's rights or requirements. I have received a copy of the "Disclosure Notice to Proposed Insured", and when applicable, the "Accelerated Benefit Insurance Rider Disclosure Statement".

For your protection, the law requires that a warning against insurance fraud appear on this application. Please see the previous page for the warning applicable to your state of residence before signing this form.

To help the government fight the funding for terrorism and money laundering activities, federal law requires all financial institutions obtain, verify, and record information that identifies each person who opens an account. What this means for you: when you apply for life insurance, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We will also ask to see your driver's license or other government issued photo identification. If you wish to have more detailed explanation of our information practices, please write to: Sagicor Life Insurance Company; Attention: Compliance Department; PO Box 52121; Phoenix, AZ 85072-2121.

Under the penalties of perjury, by my signature on this application, I certify that: (1) the Social Security number shown on this application is my correct taxpayer identification number and, (2) I am not subject to back-up withholding either because I have not been notified by the IRS that I am subject to back-up withholding as a result of a failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to back-up withholding.

Signed: _____ Date Signed: _____

City State

_____
Proposed Insured Signature
(If a minor, signature of parent or guardian)

_____
Proposed Additional Insured Signature
(If a minor, signature of parent or guardian)

_____
Proposed Owner's Signature
(If other than the Proposed Insured or Trustee)

_____
Proposed Trustee Signature *(if, applicable)*

_____
Writing Producer's Name *(Please Print)*

_____
Writing Producer's Number

_____
Writing Producer's Signature

_____
Countersigned
(Licensed resident producer if state required)

SECTION 14 – This section should be completed by the Producer.
For questions about this application or requirements, contact our Underwriting Department.

Producer Name (Please Print)	Producer ID Number	% Split

Each licensed Producer will share equally unless otherwise indicated.

1. Have you delivered the consumer protection notices to the Proposed Owner(s) and Proposed Insured(s)? ☐ Yes ☐ No
2. Did you personally meet with the Proposed Owner(s) and Proposed Insured(s), obtain their Social Security Number(s) and view for each a Government issued photo ID? *(If **YES**, specify the type of ID and ID number. If **NO**, please explain why.)* _____ ☐ Yes ☐ No
3. If premium was accepted, was the Conditional Receipt completed and delivered to the Proposed Owner? ☐ Yes ☐ No
4. Does the Proposed Insured(s) have any other life insurance or annuities currently in force or pending reinstatement? ☐ Yes ☐ No
5. Will any annuity or life insurance presently in force be replaced or changed by this policy that is being applied for? *(If **YES**, and if required by state regulation, any Replacement Comparison, Notice, or Statement must accompany this application.)* ☐ Yes ☐ No
6. Is this a 1035 Exchange? *(If **YES**, attach all required forms.)* ☐ Internal ☐ External ☐ Yes ☐ No
7. Is this a premium finance case? ☐ Yes ☐ No
8. How long have you known the Proposed Owner(s)? _____ Proposed Insured(s)? _____
9. Are you related to the Proposed Owner(s)? ☐ Yes ☐ No Proposed Insured(s)? ☐ Yes ☐ No
   If **YES**, how are you related? _____
10. Are the Proposed Owner(s) U.S. Citizen(s)? ☐ Yes ☐ No Proposed Insured(s)? ☐ Yes ☐ No
    If **NO**, how long have they been in the U.S.? _____ What type of Visa? _____
11. Does the Proposed Owner(s) understand and speak English? ☐ Yes ☐ No Proposed Insured(s)? ☐ Yes ☐ No
    If **NO**, please explain: _____
12. Was any other person present to answer questions? ☐ Yes ☐ No
    If **YES**, who was present and why? _____
13. What is the purpose of this insurance purchase? _____
14. Do you know of anything not disclosed in this application that may affect the risk of this life insurance purchase?
    ☐ Yes ☐ No If **YES**, please explain: _____
15. Sagicor is responsible for ordering all medical requirements. If the requirements are ordered by the producer, please indicate the requirements ordered and the company. Paramed Company: _____
    Date Ordered: _____ ☐ Blood Profile/HOS ☐ MD Exam ☐ Treadmill EKG ☐ EKG ☐ Paramedical Exam
16. Remarks: _____

Producer's Certification

I certify that I saw and know the Proposed Owner(s) and Proposed Insured(s) to be the person(s) described in this application, and have reviewed the appropriate documentation, and have truly and accurately recorded the information supplied by the Proposed Owner(s) and Proposed Insured(s), that I know of no condition affecting the insurability of the applicant not fully set forth in the application, and that I have made no declaration, representation, or waiver regarding coverage or the provisions or terms of the application or policy. I further certify that I am licensed in the state in which this application was completed and have delivered all required notices and disclosures and fully complied with all privacy and replacement regulations. I also assume full responsibility for the delivery of the policy and the submission of the first premium.

Signed (Writing Producer): _____ Date Signed: _____

Phone Number: _____ Fax Number: _____ E-mail Address: _____

Sagicor

LIFE INSURANCE COMPANY

Conditional Receipt ("Receipt")

Detach and leave this page with the Proposed Owner if money is submitted with the application. No payment may be accepted with the application, if, within the past three (3) years, any Proposed Insured(s) has been treated for or consulted a physician concerning heart disease, stroke, or cancer.

Make all checks payable to: **Sagicor Life Insurance Company**.
Do not make checks payable to the producer or leave the payee blank.

Received from _____ as the Proposed Owner, the sum of $ _____, for the insurance application

dated _____, with _____ as the Proposed Insured.

The policy you applied for will not become effective unless and until a policy is delivered to you, and all other conditions of coverage are met. Conditional insurance under the terms of the policy applied for may become effective as of the later of: (1) the date of application; (2) the date of the last medical examination, test and/or other screening required by Sagicor, if any (the "Effective Date"). Such conditional insurance is subject to the conditions and limitations of this Receipt. Such conditional insurance will take effect as of the Effective Date, so long as all of the following requirements are met:

1. Each Proposed Insured is found to have been insurable as of the Effective Date, exactly as applied for in accordance with Sagicor's underwriting rules and standards, without any modifications as to plan, amount, or premium rate;
2. As of the Effective Date, all statements and answers given in the application are true;
3. The payment with the application must not be less than the full initial premium for the mode of payment chosen in the application and must be received at Sagicor's Home Office within the lifetime of the Proposed Insured(s);
4. All medical examinations, tests, and other screenings required of the Proposed Insured(s) by Sagicor are completed and the results received at Sagicor's Home Office within ninety (90) days of the date the application was completed; and
5. The following items must be signed and received at Sagicor's Home Office: all parts of the application; any supplemental application; questionnaires; addendum; and/or amendment to the application.

The aggregate amount of conditional coverage provided under this Receipt, if any, and any other conditional receipt issued by Sagicor shall be limited to the lesser of the amount(s) applied for or [$500,000] of life insurance. There is no conditional coverage for riders or any additional benefits, if any, for which you have applied.

There will be no conditional insurance coverage and the Company's liability will be limited to returning any premium submitted to the Company with this Receipt if any of the following occurs: (a) one or more of the Receipt's conditions have not been met exactly; (b) a Proposed Insured(s) dies by suicide; or (c) the Company does not approve and accept the application for insurance within ninety (90) days of the date the Proposed Insured(s) and/or Proposed Owner(s) signed the application, thus deeming the application rejected by the Company.

Any conditional coverage provided by this Receipt will terminate on the earliest of: (a) ninety (90) days from the date the application was signed; (b) the date Sagicor either mails a notice to the Proposed Owner(s) rejecting the application and/or mails a refund of any amount paid with the application; (c) when the insurance applied for goes into effect under the terms of the policy applied for; or (d) the date Sagicor offers to provide insurance on terms that differ from the insurance for which you have applied.

This Receipt is not valid unless all blanks are completed above and this Receipt is signed by the producer. This Receipt does not provide any conditional insurance until all of the conditions and requirements are met as outlined above.

Dated at _____ on _____ _____
City *State* *Date* *Producer's Signature*

Sagicor

LIFE INSURANCE COMPANY

Disclosure Notice to Proposed Insured

Leave with the Proposed Insured

Investigative Consumer Report Notice

You are our most important source of information, but personal information may also be collected from other sources. Such information may, in certain circumstances, be disclosed to third parties without your authorization.

An investigative consumer report may be prepared in which information is obtained from public records and through personal interviews with: your neighbors, friends, employers, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living. You may request to be interviewed as part of the report. Upon written request to Sagicor, further information on the nature and scope of the report will be provided.

Information Practices

Personal information we obtain during the underwriting process is private and confidential. We will not disclose such information to other persons or organizations without your written authorization, except to the extent necessary to conduct our business, as permitted by law, or as required by law. You have the right to be told about and obtain access to certain items or personal information in our files. You also have the right to request correction of information you believe to be inaccurate. If you would like to receive a more detailed explanation of our information practices, please write to:

Sagicor Life Insurance Company
Attention: Compliance Department
P.O. Box 52121
Phoenix, AZ 85072-2121

Medical Information Bureau (MIB) Notice

Information regarding your insurability will be treated as confidential. Sagicor or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau (MIB). The MIB is a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member company for life insurance or health insurance coverage, or a claim for benefit is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734. MIB's toll free number is 866-692-6901 or TTY 866-346-3642. Website www.mib.com.

Sagicor Life Insurance Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

Sagicor
LIFE INSURANCE COMPANY

INDIVIDUAL LIFE INSURANCE
SIMPLIFIED ISSUE APPLICATION

SECTION 1 – Select Coverage

Face Amount being Applied For: $ _____ [Do Not Exceed [$75,000]]

Gold Series Products

[☐ Whole Life]

[☐ Other Gold or Platinum Series Plan Not Listed] _____

Platinum Series Products

[☐ No Lapse Universal Life]

Universal Life Elections (select one)

Guideline Premium Test ☐

Cash Value Accumulation Test ☐

Death Benefit Option (select one)

[☐ A] [☐ B]

Optional Riders Applied For: ***Not all of the riders are available for all products in all states***

[☐ Accidental Death Benefit] $ _____

[☐ Accident Disability Income Benefit] $ _____

[☐ Guaranteed Insurability Option]

[☐ Waiver of Premium]

[☐ Waiver of Monthly Deductions]

[☐ Children's Term (Complete Children's Term Rider Application and attach)]

Automatic Premium Loan Option (select one) [☐ Yes ☐ No] [(Whole Life Only)]

SECTION 2 – Simplified Issue Questions

	Proposed Insured
1. Do you currently require oxygen therapy or kidney dialysis? Have you been told that you need an organ transplant? Have you been diagnosed with diabetes, hepatitis, or paralysis?	☐ Yes ☐ No
2. Do you require assistance to perform any 2 of 6 Activities of Daily Living (ADL's)? (ADL's are: eating, toileting, transferring, bathing, dressing, and continence.) Are you a resident in a nursing home or assisted living facility? In the past twelve (12) months, have you been disabled for more than thirty (30) days or received disability benefits of any kind?	☐ Yes ☐ No
3. Have you tested positive for Human Immunodeficiency Virus (HIV); or been medically diagnosed as having Acquired Immune Deficiency Syndrome(AIDS); or been medically diagnosed as having AIDS Related Complex (ARC)?	☐ Yes ☐ No
4. In the past twenty-four (24) months, have you been hospitalized two (2) or more times? (Do not include: stays of less than three (3) days/72 hours, pregnancy or childbirth related stays, or cosmetic surgery.)	☐ Yes ☐ No
5. In the past thirty-six (36) months, have you been treated for or diagnosed with any cancer (other than Basal Cell skin cancer), leukemia, hypertension, had a heart attack, stroke, heart failure, or heart surgery (including angioplasty)?	☐ Yes ☐ No
6. In the past thirty-six (36) months, have you used any illegal drugs, or been treated for or advised to have treatment for drug or alcohol abuse, or mental or emotional problems?	☐ Yes ☐ No
7. In the last five (5) years, have you been convicted of, or are you awaiting trial for a felony?	☐ Yes ☐ No
8. Have you ever had an application for insurance or reinstatement of insurance declined, rated, or postponed?	☐ Yes ☐ No

SECTION 3 – Proposed Insured Information

Name: _____ Sex: ☐ Male ☐ Female
(First) (MI) (Last)

Street Address: _____
City State ZIP Code

Former Address: _____
(If at current address less than 2 years) City State ZIP Code

Telephone No. : Home _____ Work _____ Other _____

Social Security Number: _____ Driver's License Number/State: _____

E-Mail Address: _____ Marital Status: _____

Date of Birth: _____ Place of Birth: _____ Height: _____ Weight: _____

Has the Proposed Insured used any form of tobacco in the past 24 months? ☐ Yes ☐ No

Employer's Name: _____ Occupation: _____

Is the Proposed Insured a U.S. Citizen? ☐ Yes ☐ No Alien Registration Number: _____

(If **NO**, please complete a Foreign Travel & Residence Questionnaire & provide an Alien Registration Number.)

SECTION 4 – Proposed Owner Information

(If it is different from the Proposed Insured. If this is a Trust, please provide a copy of the Title and Signature page.)

Name: _____ Date of Birth/Trust Date: _____
(First) (MI) (Last)

Street Address: _____ SSN/Tax ID #: _____
City State ZIP Code

Telephone No. : Home _____ Work _____ Other _____

E-Mail Address: _____ Driver's License Number/State: _____

Is the Proposed Owner a U.S. Citizen? ☐ Yes ☐ No Alien Registration Number: _____

(If **NO**, please complete a Foreign Travel & Residence Questionnaire & provide an Alien Registration Number.)

SECTION 5 – Beneficiary Information *(If there are Additional Beneficiaries, attach information on a separate sheet of paper.)*

Primary Beneficiary Name: _____ Relationship: _____

Street Address: _____
City State ZIP Code

Social Security Number/Tax ID: _____ Date of Birth/Trust Date: _____

Is the Primary Beneficiary a U.S. Citizen? ☐ Yes ☐ No Alien Registration Number: _____

(If **NO**, please complete a Foreign Travel & Residence Questionnaire & provide an Alien Registration Number.)

Contingent Beneficiary Name: _____ Relationship: _____

Street Address: _____
City State ZIP Code

Social Security Number/Tax ID: _____ Date of Birth/Trust Date: _____

Is the Contingent Beneficiary a U.S. Citizen? ☐ Yes ☐ No Alien Registration Number: _____

(If **NO**, please complete a Foreign Travel & Residence Questionnaire & provide an Alien Registration Number.)

SECTION 6 – Premium Information

☐ Tobacco ☐ Non-Tobacco

Premium Collected with Application: $ _____ Transfer/1035 Exchange: ☐ Yes ☐ No Amount: $ _____

Planned Modal Premium: $ _____ Draft Initial Premium: ☐ Yes ☐ No

Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly EFT (Complete an Electronic Funds Transfer (EFT) Authorization)

SECTION 7 – Payor Information

(If different from the Proposed Owner. If this is a Trust, please provide a copy of the Title and Signature page.)

Name: _____ Date of Birth/Trust Date: _____

(First) (MI) (Last)

Street Address: _____ SSN/Tax ID #: _____

City State ZIP Code

Telephone No. : Home _____ Work _____ Other _____

E-Mail Address: _____ Driver's License Number/State: _____

Is the Payor a U.S. Citizen? ☐ Yes ☐ No Alien Registration Number: _____

(If **NO**, please complete a Foreign Travel & Residence Questionnaire & provide an Alien Registration Number.)

Relationship to the Proposed Owner/Proposed Insured: _____

NOTICE: State insurance law may prohibit the owner of a life insurance policy from entering into an agreement to sell, transfer, or assign a life insurance policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued. You should consult with legal advisors if you have any questions about these matters.

SECTON 8 – Additional Information/Special Request or Instructions

SECTION 9 – In Force/Replacement Information

1. Will any life insurance or annuity in this or any other company be replaced or changed as a result of this application? *(If **YES**, please list the policy or contract below & complete a Replacement Form.)* ☐ Yes ☐ No
2. Does the Proposed Insured:
   a) Have any other life insurance or annuity in force? ☐ Yes ☐ No
   b) Have any application (including reinstatement) for life insurance or annuity now pending? ☐ Yes ☐ No
3. Has the Proposed Insured applied for any life insurance or annuity in the last ninety (90) days? ☐ Yes ☐ No
   *(If **YES**, please list the policy or contract below.)*

Name of Proposed Insured	Company	Policy #	Amount	Issue Date	Plan Type

SECTION 10 – Fraud Warning

District of Columbia, Alabama, Arizona, Arkansas, California, Delaware, Illinois, Montana, Nevada, North Dakota, South Dakota: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Florida Residents Only: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New Jersey Residents Only: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Oregon Residents Only: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

SECTION 11 – Authorization and Acknowledgement

I understand that I am applying for life insurance coverage issued by Sagicor Life Insurance Company ("Sagicor"). I understand and consent that this application, and information obtained pursuant to this authorization may be used by Sagicor to evaluate my eligibility for life insurance.

I authorize the release to Sagicor of all information requested about me or any of my minor children proposed to be insured. This information may be released to Sagicor's authorized representatives. Authorized representatives include any consumer reporting agency acting on their behalf. Each of the following may be a source of information: the Medical Information Bureau, Inc. ("MIB"); my employer; physician, medical practitioner, hospital, clinic, or medically related facility; insurance or reinsuring company; consumer reporting agency; any other organization or insurance support organization; and a Pharmacy Benefit Manager.

Information means facts about me or any of my minor children that are proposed to be insured. Those facts include, but are not limited to; information about mental or physical health; other insurance coverage; use of drugs or alcohol; motor vehicle records; avocations; employment; prescription drug records; hazardous activities; character; general reputation; mode of living; finances; vocation; and other personal traits.

I understand and agree that Sagicor may disclose all or some of my information to its insurance administrators, its reinsurance companies, the producer who solicited my application and his or her principals, the MIB, and other persons or organizations performing business or legal services in connection with my application.

This authorization shall be valid for 30 months. I understand that I or my authorized representative may receive a copy of the authorization upon request. I agree that a photographic copy of this authorization shall be as valid as the original. I understand that I may revoke this authorization at any time by sending written notice to Sagicor's home office. I understand that my right to revoke this authorization is limited to the extent that Sagicor has not already taken action in reliance on the authorization.

To the best of my knowledge and belief, the statements and answers given on this form are true, complete, and correctly recorded. I understand that a policy does not go into effect and no liability exists for Sagicor until the policy is delivered and accepted by the Owner(s), the first full premium is paid and there has been no change in the health of the Proposed Insured that would change any of the answers in this application. I understand and agree that no producer may accept risks or pass upon insurability, make or modify contracts, or waive any of Sagicor's rights or requirements. I have received a copy of the "Disclosure Notice to Proposed Insured", and when applicable, the "Accelerated Benefit Insurance Rider Disclosure Statement".

For your protection, the law requires that a warning against insurance fraud appear on this application. Please see the previous page for the warning applicable to your state of residence before signing this form.

To help the government fight the funding for terrorism and money laundering activities, federal law requires all financial institutions obtain, verify, and record information that identifies each person who opens an account. What this means for you: when you apply for life insurance, we will ask for your name, address, date of birth and other information that will allow us to identify you. We will also ask to see your driver's license or other government issued photo identification. If you wish to have more detailed explanation of our information practices, please write to: Sagicor Life Insurance Company; Attention: Compliance Department; PO Box 52121; Phoenix, AZ 85072-2121.

Under the penalties of perjury, by my signature on this application, I certify that: (1) the Social Security number shown on this application is my correct taxpayer identification number, and (2) I am not subject to back-up withholding either because I have not been notified by the IRS that I am subject to back-up withholding as a result of a failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to back-up withholding.

Signed: _____ Date Signed: _____

City State

_____

Proposed Insured Signature
(If a minor, signature of parent or guardian)

_____ _____

Proposed Owner's Signature
(If other than the Proposed Insured or Trustee)

Proposed Trustee Signature *(if, applicable)*

_____ _____

Writing Producer's Name *(Please Print)*

Writing Producer's Number

_____ _____

Writing Producer's Signature

Countersigned
(Licensed resident producer if state required)

SECTION 12 – This section should be completed by the Producer.

For questions about this application or requirements, contact our Underwriting Department.

Producer Name (Please Print)	Producer ID Number	% Split

Each licensed Producer will share equally unless otherwise indicated.

1. Have you delivered the consumer protection notices to the Proposed Owner(s) and Proposed Insured(s)? ☐ Yes ☐ No
2. Did you personally meet with the Proposed Owner(s) and Proposed Insured(s), obtain their Social Security Number(s) and view for each a government issued photo ID? *(If **YES**, specify the type of ID and ID number. If **NO**, please explain why.)* _____ ☐ Yes ☐ No
3. If premium was accepted, was the Conditional Receipt completed and delivered to the Proposed Owner? ☐ Yes ☐ No
4. Does the Proposed Insured(s) have any other life insurance or annuities currently in force or pending reinstatement? ☐ Yes ☐ No
5. Will any annuity or life insurance presently in force be replaced or changed by this policy that is being applied for? *(If **YES**, and if required by state regulation, any Replacement Comparison, Notice, or Statement must accompany this application.)* ☐ Yes ☐ No
6. Is this a 1035 Exchange? *(If **YES**, attach all required forms.)* ☐ Internal ☐ External ☐ Yes ☐ No
7. How long have you known the Proposed Owner(s)? _____ Proposed Insured(s)? _____
8. Are you related to the Proposed Owner(s)? ☐ Yes ☐ No Proposed Insured(s)? ☐ Yes ☐ No
   If **YES**, how are you related? _____
9. Are the Proposed Owner(s) U.S. Citizen(s)? ☐ Yes ☐ No Proposed Insured(s)? ☐ Yes ☐ No
   If **NO**, how long have they been in the U.S.? _____ What type of Visa? _____
10. Does the Proposed Owner(s) understand and speak English? ☐ Yes ☐ No Proposed Insured(s)? ☐ Yes ☐ No
    If **NO**, please explain: _____
11. Was any other person present to answer questions? ☐ Yes ☐ No
    If **YES**, who was present and why? _____
12. What is the purpose of this insurance purchase? _____
13. Do you know of anything not disclosed in this application that may affect the risk of this life insurance purchase?
    ☐ Yes ☐ No If **YES**, please explain: _____
14. Remarks: _____

Producer's Certification

I certify that I saw and know the Proposed Owner(s) and Proposed Insured(s) to be the person(s) described in this application, and have reviewed the appropriate documentation, and have truly and accurately recorded the information supplied by the Proposed Owner(s) and Proposed Insured(s), that I know of no condition affecting the insurability of the applicant not fully set forth in the application, and that I have made no declaration, representation, or waiver regarding coverage or the provisions or terms of the application or policy. I further certify that I am licensed in the state in which this application was completed and have delivered all required notices and disclosures and fully complied with all privacy and replacement regulations. I also assume full responsibility for the delivery of the policy and the submission of the first premium.

Signed (Writing Producer): _____ Date Signed: _____

Phone Number: _____ Fax Number: _____ E-mail Address: _____

Sagicor

LIFE INSURANCE COMPANY

Conditional Receipt ("Receipt")

Detach and leave this page with the Proposed Owner if money is submitted with the application. No payment may be accepted with the application, if, within the past three (3) years, any Proposed Insured has been treated for or consulted a physician concerning heart disease, stroke, or cancer.

Make all checks payable to: **Sagicor Life Insurance Company**.
Do not make checks payable to the producer or leave the payee blank.

Received from _____ as the Proposed Owner, the sum of $ _____, for the insurance application

dated _____, with _____ as the Proposed Insured.

The policy you applied for will not become effective unless and until a policy is delivered to you, and all other conditions of coverage are met. Conditional insurance under the terms of the policy applied for may become effective as of the later of: (1) the date of application; (2) the date of the last medical examination, test and/or other screening required by Sagicor, if any (the "Effective Date"). Such conditional insurance is subject to the conditions and limitations of this Receipt. Such conditional insurance will take effect as of the Effective Date, so long as all of the following requirements are met:

1. Each Proposed Insured is found to have been insurable as of the Effective Date, exactly as applied for in accordance with Sagicor's underwriting rules and standards, without any modifications as to plan, amount, or premium rate;
2. As of the Effective Date, all statements and answers given in the application are true;
3. The payment with the application must not be less than the full initial premium for the mode of payment chosen in the application and must be received at Sagicor's Home Office within the lifetime of the Proposed Insured(s);
4. All medical examinations, tests, and other screenings required of the Proposed Insured(s) by Sagicor are completed and the results received at Sagicor's Home Office within ninety (90) days of the date the application was completed; and
5. The following items must be signed and received at Sagicor's Home Office: all parts of the application; any supplemental application; questionnaires; addendum; and/or amendment to the application.

The aggregate amount of conditional coverage provided under this Receipt, if any, and any other conditional receipt issued by Sagicor shall be limited to the lesser of the amount(s) applied for, or [$75,000] of life insurance. There is no conditional coverage for riders or any additional benefits, if any, for which you have applied.

There will be no conditional insurance coverage and the Company's liability will be limited to returning any premium submitted to the Company with this Receipt if any of the following occurs: (a) one or more of the Receipt's conditions have not been met exactly; (b) a Proposed Insured(s) dies by suicide; or (c) the Company does not approve and accept the application for insurance within ninety (90) days of the date the Proposed Insured(s) and/or Proposed Owner(s) signed the application, thus deeming the application rejected by the Company.

Any conditional coverage provided by this Receipt will terminate on the earliest of: (a) ninety (90) days from the date the application was signed; (b) the date Sagicor either mails a notice to the Proposed Owner(s) rejecting the application and/or mails a refund of any amount paid with the application; (c) when the insurance applied for goes into effect under the terms of the policy applied for; or (d) the date Sagicor offers to provide insurance on terms that differ from the insurance for which you have applied.

This Receipt is not valid unless all blanks are completed above and this Receipt is signed by the producer. This Receipt does not provide any conditional insurance until all of the conditions and requirements are met as outlined above.

Dated at _____ on _____ _____

City *State* *Date* *Producer's Signature*

Sagicor

LIFE INSURANCE COMPANY

Disclosure Notice to Proposed Insured

Leave with the Proposed Insured

Investigative Consumer Report Notice

You are our most important source of information, but personal information may also be collected from other sources. Such information may, in certain circumstances, be disclosed to third parties without your authorization.

An investigative consumer report may be prepared in which information is obtained from public records and through personal interviews with: your neighbors, friends, employers, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living. You may request to be interviewed as part of the report. Upon written request to Sagicor, further information on the nature and scope of the report will be provided.

Information Practices

Personal information we obtain during the underwriting process is private and confidential. We will not disclose such information to other persons or organizations without your written authorization, except to the extent necessary to conduct our business, as permitted by law, or as required by law. You have the right to be told about and obtain access to certain items or personal information in our files. You also have the right to request correction of information you believe to be inaccurate. If you would like to receive a more detailed explanation of our information practices, please write to:

Sagicor Life Insurance Company
Attention: Compliance Department
P.O. Box 52121
Phoenix, AZ 85072-2121

Medical Information Bureau (MIB) Notice

Information regarding your insurability will be treated as confidential. Sagicor or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau (MIB). The MIB is a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member company for life insurance or health insurance coverage, or a claim for benefit is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734. MIB's toll free number is 866-692-6901 or TTY 866-346-3642. Website www.mib.com.

Sagicor Life Insurance Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

Sagicor

LIFE INSURANCE COMPANY

4343 N. SCOTTSDALE RD., SUITE 300
SCOTTSDALE, ARIZONA 85251/1-888-724-4267

AMENDMENT TO POLICY NO. [Policy No.]

I, [John Doe], AMEND MY APPLICATION TO SAGICOR LIFE INSURANCE COMPANY AS FOLLOWS:

I ACCEPT THIS POLICY AS ISSUED ON THE [20 Year Term] PLAN OF INSURANCE IN THE AMOUNT OF [$0.00]. THIS WILL SERVE TO AFFIRM THAT THE POLICY IS ISSUED WITH

[Text]

THE APPLICATION SIGNED IN [Phoenix] WITH THE EFFECTIVE DATE AS [January 1, 2006].

PLAN [20 Year Term] AMOUNT [$0.00] PREMIUM [$0.00]

SINCE THE DATE OF YOUR APPLICATION:

	YES	NO
1) HAS THE PRIMARY INSURED HAD ANY INJURY OR BEEN DIAGNOSED OR TREATED FOR ANY DISEASE OR ILLNESS?		
2) HAS ANY CHANGE OCCURRED IN THE PRIMARY INSURED'S OCCUPATION?		
3) HAS THE PRIMARY INSURED CONSULTED A DOCTOR OR OTHER PRACTITIONER?		
4) HAS THE PRIMARY INSURED RECEIVED ANY ADDITIONAL INFORMATION ABOUT HIS/HER PHYSICAL CONDITION?		

FOR ALL 'YES' ANSWERS TO THE ABOVE QUESTIONS, PLEASE EXPLAIN:

_____

_____

TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE STATEMENTS AND ANSWERS GIVEN ON THIS FORM ARE TRUE, COMPLETE, AND CORRECTLY RECORDED. I AGREE THAT THEY SHALL BE CONSIDERED A PART OF THE APPLICATION AND POLICY REFERENCED ON THIS FORM.

DATE _____ DATED AT _____
CITY STATE

SIGNED _____ SIGNED _____
INSURED OWNER, IF OTHER THAN INSURED

SIGNED _____ DATE _____
PRODUCER

RETAIN ONE COPY FOR YOUR RECORDS

Sagicor
LIFE INSURANCE COMPANY

FIXED INDEXED SUPPLEMENTAL APPLICATION

Proposed Insured/Owner:

Name: _____
(First) *(Middle)* *(Last)*

Social Security Number: _____ Date of Birth: _____

Proposed Joint Owner/Insured:

Name: _____
(First) *(Middle)* *(Last)*

Social Security Number: _____ Date of Birth: _____

Fixed Indexed Plan Selection:

- ☐ Gold Series Fixed Indexed Single Premium Whole Life
- ☐ Gold Series Fixed Indexed 7 Pay Whole Life
- ☐ Platinum Series Fixed Indexed Single Premium Deferred Annuity
  - ☐ with Bonus Interest
  - ☐ without Bonus Interest
- ☐ Platinum Series Fixed Indexed Universal Life
- ☐ Other _____

Premium Allocation: Initial Premium

Declared Rate Strategy	%
Indexed Strategy 1 – S&P 500® Index	%
Indexed Strategy 2 – Russell® 2000 Index, Hang Seng Index & EURO STOXX 50® Index	%
Total:	100 %

Proposed Owners Statement:

I understand that I am applying for a fixed indexed insurance product and that the values in the Contract/Policy may be affected by an external index. The Contract/Policy does not directly participate in any stock equity investments. The statements and answers given in this supplement are true, complete and correctly recorded to the best of my knowledge and belief. Upon written request, the Company is required to provide reasonable, factual information regarding the benefits and provisions of the Contract/Policy. If for any reason I/We are not satisfied with the Contract/Policy, I/We may return it to the Company or any of its producers within thirty (30) days from the date I/We received it for a full refund of the premium paid.

Signed at (City/State): _____ Date: _____

_____
Signature of Proposed Owner/Insured

_____
Signature of Proposed Joint Owner/Insured

_____
Producer Name (please print)

_____
Producer Number

_____
Signature of Producer

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FOREIGN TRAVEL AND RESIDENCE QUESTIONNAIRE

Proposed Insured Information:

Name: _____ Social Security: _____

Foreign Travel/Residence Information:

1. Country of Origin: _____
2. Current Citizenship: _____
3. Date of entry into the United States: _____
4. Visa type, symbol, number and expiration date: _____
5. Do you intend to remain permanently in the USA? *(If No, please provide details below)* ☐ Yes ☐ No
6. Do you plan to travel or reside outside the USA? *(If Yes, please provide details below)* ☐ Yes ☐ No

Please provide details for each country to include specific locations, departure dates, duration and purpose for each:

_____

_____

_____

_____

_____

It is represented that the statements and answers given in this supplement are true, complete and correctly recorded to the best of my knowledge and belief. It is agreed that this supplement shall be a part of the application for life insurance for the Proposed Insured(s).

Signed at: _____ Date: _____

Signature of Proposed Insured: **X** _____

Signature of Owner *(if other than Proposed Insured)*: **X** _____

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AVIATION QUESTIONNAIRE

1. Name of Proposed Insured: _____

2. Hours flown for pilots, students and crew members:

a) _____ (Total of all hours flown) _____ (Pilot) _____ (Type of aircraft)

b) _____ (Total hours in past 12 months) _____ (Pilot) _____ (Type of aircraft)

c) _____ (Estimated hours in next 12 months) _____ (Pilot) _____ (Type of aircraft)

d) _____ (Date of last flight) _____ (Pilot) _____ (Type of aircraft)

e) _____ (If crew member state number of flights per year) _____ (Total hours spent flying)

f) _____ (If crew member, state duties)

3. Pilot's certificate(s) currently held:

☐ Private ☐ Student ☐ Airline Transportation Rating (ATR)
☐ Commercial ☐ Flight Instructor ☐ Instrument Flight Rating (IFR)

4. Types of flying:

☐ Pleasure ☐ Instructor ☐ Commuter ☐ Crop Dusting ☐ Glider
☐ Scheduled Airline ☐ Military (see Military section) ☐ Freight Carry or Passenger Service
☐ Personal Business ☐ Charter or Unscheduled Airline ☐ Employer Aircraft or Employee Transportation
☐ Other Explain: _____

5. Flying history: Explain any Yes answers in Remarks section.

a) Medical certificate held: ☐ Class III ☐ Class II ☐ Class I
b) Was Medical certificate granted subject to limitations for physical waivers? ☐ Yes ☐ No
c) Have you ever been grounded or had your license revoked? ☐ Yes ☐ No
d) Have you in the past 2 years flown or do you intend to fly outside the U.S. or Canada as a pilot or crew member? ☐ Yes ☐ No
e) Have you ever flown or do you intend to fly ultra lights, biplanes, prototypes, experimental or personally built or assembled aircraft? ☐ Yes ☐ No

6. Military

a) Branch of service: _____ Rank: _____ Pay grade: _____
b) Status: ☐ Active Duty ☐ Active Reserve or National Guard ☐ Inactive ☐ R.O.T.C.
c) Type of aircraft currently used as: ☐ Pilot ☐ Crew
☐ Attack ☐ Fighter ☐ Observation ☐ Reconnaissance ☐ Bomber ☐ Helicopter
☐ Patrol ☐ Tanker ☐ Trainer ☐ Transport (☐ MAC or ☐ FLSW)
☐ Other explain: _____
☐ Proficiency rating: _____
d) Have you been alerted for transfer or do you expect to leave this country during the next year? Explain Yes answer in Remarks section. ☐ Yes ☐ No

Remarks _____

I represent, to the best of my knowledge and belief, that all the above statements and answers are complete and true. I agree that they will form a part of my application and become a part of any contract of insurance issued as a result of that application.

Dated at _____ (City and State) this _____ day of _____ 20 _____.

_____ Witness

_____ Signature of Proposed Insured

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AVOCATION QUESTIONNAIRE

1. **Name of Proposed Insured:** _____

2. **Underwater Diving**
   a) Have you engaged in or do you intend to engage in:
   ☐ night diving ☐ free/breath hold diving ☐ ice diving
   ☐ treasure diving ☐ cave diving ☐ rescue/recovery
   ☐ diving alone ☐ exploration of sunken wrecks ☐ instruction
   Date of last participation for any of the above activities: _____
   b) Average depth achieved: _____ ft. Maximum depth achieved: _____ ft.
   How often have you achieved this maximium depth: _____
   c) Estimate number of dives: Last 12 months: _____ Next 12 months: _____
   d) Indicate type of equipment used and Certifications: _____

3. **Aerial Sports**
   a) Type: ☐ skydiving ☐ hang gliding ☐ parachuting ☐ ballooning ☐ other _____
   b) Estimate number of dives, jumps, flights: Last 12 months: _____ Next 12 months: _____
   c) Average height: _____ ft. Maximum height of: _____ ft. Maximum duration: _____ min/hrs
   d) Type of equipment: ☐ assembled from a factory kit ☐ for experimental use
   ☐ homemade ☐ purchased completely assembled
   e) Provide details of any stunt or exhibition jumps: _____
   f) Status: ☐ Professional ☐ Amateur Name of affiliated Association: _____

4. **Motor Sports**
   a) Indicate type:
   Automobile: ☐ Midget ☐ Go-kart ☐ Sports Car ☐ Stock ☐ Modified ☐ Drag
   Motorcycle: ☐ Drag ☐ Scramble ☐ Hill Climbing
   Motorboat: ☐ Unmodified ☐ Modified ☐ Experimental ☐ Jet ☐ Unlimited Hydroplane
   Other (category and type): _____
   b) Type of Track: ☐ Dirt ☐ Closed Circuit ☐ Paved ☐ Drag Strip ☐ Oval ☐ Hill Climb
   ☐ Other: _____
   c) Vehicle Data: Make & Model: _____ Displacement: _____
   Average Speed (MPH): _____ Maximum Speed (MPH): _____
   d) Number of Races for each method and frequency:
   Vehicle vs. Vehicle: Within the last 3 years: _____ Next 12 months: _____
   Vehicle vs. Clock: Within the last 3 years: _____ Next 12 months: _____
   e) Status: ☐ Professional ☐ Amateur Name of affiliated Association: _____

5. **Rock or Mountain Climbing; Spelunking or Bungee Jumping**
   a) Specify Sport/Activity: _____
   b) Give exact location where each activity takes place: _____
   c) Describe safety equipment used: _____
   d) Club affiliation: Amateur or Professional _____
   e) Frequency of Participation: Last 12 months: _____ Next 12 months: _____

Remarks: _____

I represent, to the best of my knowledge and belief, that all the above statements and answers are complete and true. I agree that they will form a part of my application and become a part of any contract of insurance issued as a result of that application.

Signed at _____ this _____ day of _____ 20 _____
(City and State)

_____ _____
Signature of Proposed Insured Signature of Proposed Owner *(if other than Proposed Insured)*

_____
Signature of Producer

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LIFE INSURANCE COMPANY

FINANCIAL QUESTIONNAIRE (PERSONAL)

Full Name: _____

1. Your Income
   - A. Salary or Wages _____
   - B. Bonuses and/or Commissions _____
   - C. Other Income _____
   - D. Unearned income (interest and dividends) _____
   - E. Spouse's income _____

   Total Income _____

2. What is your approximate Net Worth (Assets minus Liabilities)
   - Assets _____
   - \- Liabilities _____
   - **=** Net Worth _____

3. Estimated Tax Liabilities at Death _____
   (Include potential Estate Taxes, Inheritance Taxes, Capital Gains Taxes, both Federal and State) _____

4. Please provide the following:
   - A. Amount of Insurance applied for with this company _____
   - B. Amount of Insurance applied for with other companies _____
   - C. Amount of Life Insurance you already have in force _____
   - D. Amount of Life Insurance you intend to have in force _____

5. Have you ever filed for bankruptcy? _____
   If yes, was it discharged? _____

6. How was the need for this amount of coverage determined?

_____

_____

_____

_____

I represent, to the best of my knowledge and belief, that all the above statements and answers are complete and true. I agree that they will form a part of my application and become a part of any contract of insurance issued as a result of that application.

Dated at _____ this _____ day of _____, 20_____
(City and State)

_____
Signature of Proposed Insured

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FINANCIAL QUESTIONNAIRE (BUSINESS)

Full Name: _____

1. Purpose of Business Insurance
___ Keyman ___ Buy/Sell Agreement ___Stock Repurchased ___Deferred Compensation

If there is a written agreement for the purpose of coverage, please attach a copy.

2. Type of business structure
___ Corporation ___ Partnership ___ Sole Proprietorship ___ LLC

3. Name of the business?

_____

4. Name of owners and percent of ownership?

_____

_____

5. Are other Corporate Officers or Partners being insured? _____

6. Estimated Fair Market Value of the business _____

7. What method or methods were used to estimate the value? (i.e. Capitalization of earnings, book value, years purchase…) If professional valuation is used, please provide a copy of the report.

8. Financial details of the business:	Current year	Previous Year
Total Assets		
Total Liabilities		
Gross Sales or Revenue		
Net Income (before taxes)		

9. Business Statements
Please include the last 2 years and current year to date copies of the following:
a. Balance Sheet
b. Income Statement
c. Cash Flow Statement
d. Notes to all business statements
e. Federal Tax returns

I represent, to the best of my knowledge and belief, that all the above statements and answers are complete and true. I agree that they will form a part of my application and become a part of any contract of insurance issued as a result of that application.

Dated at _____ this _____ day of _____ 20_____
(City and State)

_____ _____
Signature of Proposed Insured Title or position with business

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LIFE INSURANCE COMPANY

ALCOHOL/DRUG QUESTIONNAIRE

Name of Proposed Insured: _____ Application Number _____

A. ALCOHOL USE

1. Do you use alcoholic beverages? ☐ Yes ☐ No

   If yes, please give details

   a. What type: ☐ Beer ☐ Liquor ☐ Mixed ☐ Wine

   b. How much? _____

   c. How often? _____

2. Have you ever used alcoholic beverages in the past and quit? ☐ Yes ☐ No

   If yes, please give details:

   a. How much did you drink _____

   b. How long did you drink _____

   c. Date you stopped drinking _____

   d. Reason(s) you stopped drinking _____

3. Have you ever consulted, been advised by, or been actively treated by any physician or facility regarding the use of alcohol? ☐ Yes ☐ No

   If yes, please give details:

   a. Date of treatment(s) _____

   b. Number of treatments _____

   c. Name and address of last treatment facility _____

   _____

4. Have you attended Alcoholic Anonymous meetings? ☐ Yes ☐ No

   If yes, please give details:

   a. Date of last meeting attended _____

   b. Number of years attended _____

   c. Frequency of attendance _____

B. DRIVING RECORD

1. Driver's license number _____
2. Licensing state or province _____
3. Have you been convicted for any moving traffic violations in the past three years? ☐ Yes ☐ No

   If yes, please give details: _____

4. Have you had any traffic accidents in the past three years? ☐ Yes ☐ No

   If yes, please indicate dates(s) and if Proposed Insured was at fault:

Dates	Proposed Insured At Fault?
_____	☐ Yes ☐ No
_____	☐ Yes ☐ No
_____	☐ Yes ☐ No

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ALCOHOL/DRUG QUESTIONNAIRE (continued)

C. DRUG USE

In the past 10 years, have you used:

1. Opiates (codeine, heroin, horse, smack, junk, etc.)? ☐ Yes ☐ No
2. Barbiturates (seconal, phenobarbital, downers, goofballs, etc.)? ☐ Yes ☐ No
3. Methaqualone (qualude, ludes, quads, love drug, etc.)? ☐ Yes ☐ No
4. Amphetamines (benzedrine, Dexedrine, preludin, speed, uppers, etc.)? ☐ Yes ☐ No
5. Cocaine (coke, crack, blow, snow, toot, etc.)? ☐ Yes ☐ No
6. Hallucinogens (LSD, peyote, acid, fluts, etc.)? ☐ Yes ☐ No
7. Cannabis (marijuana, hashish, pot, grass, weed, etc.)? ☐ Yes ☐ No
8. Benzodiazepines (librium, valium, ativan, dalmane, etc.) ? ☐ Yes ☐ No
9. Methadone (dollies, pain killers, etc.)? ☐ Yes ☐ No
10. PCP (angel dust, peace pill, hog. etc.)? ☐ Yes ☐ No
11. Other Drugs? ☐ Yes ☐ No

If "Yes" to any question 1 through 11, give details below:

Type or Name of Drug	How Often Used	Dosage/Amount	Date From	Date to

Additional Remarks: (Details of any medical treatment, names of physicians, side effects, etc.)

I represent, to the best of my knowledge and belief, that all the above statements and answers are complete and true. I agree that they will form a part of my application and become a part of any contract of insurance issued as a result of that application.

Dated at _____ this _____ day of _____, 20_____ .
(City and State)

X_____
Signature of Proposed Insured

SERFF Tracking Number:	*AMFD-126742830*	*State:*	*Arkansas*
Filing Company:	*Sagicor Life Insurance Company*	*State Tracking Number:*	*46407*
Company Tracking Number:	*5033, 5034*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life Applications*		
Project Name/Number:	*/5033, 5034*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachment:
Readability Certification.pdf

Item Status: **Status Date:**

Satisfied - Item: Statement of Variability
Comments:
Attachment:
STATEMENT OF VARIABILITY 07-27-10.pdf

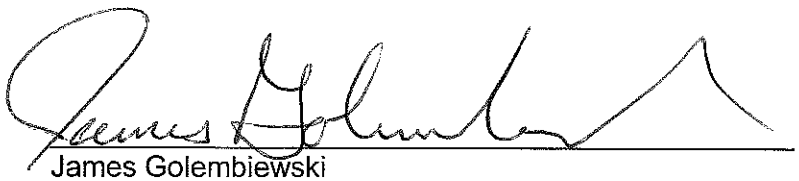
READABILITY CERTIFICATION

To Whom It May Concern:

This is to certify that the attached forms achieved a Flesch Reading Ease Score and are in compliance with applicable laws and regulations as follows:

Form #	Title	Flesch Score
5033	Life Insurance Application	51.4
5034	Life Insurance Simplified Issue Application	50.5
5035	Application Amendment	56.6
5032	Fixed Indexed Supplemental Application	53.1
5070	Foreign Travel and Residence Questionnaire	57.5
5071	Aviation Questionnaire	59.4
5076	Avocation Questionnaire	51.0
5073	Financial Questionnaire (Personal)	67.3
5074	Financial Questionnaire (Business)	58.1
5075	Alcohol/Drug Questionnaire	50.3

Sagicor Life Insurance Company



James Golembiewski
Assistant Vice President, Associate General Counsel

July 27, 2010
Date

STATEMENT OF VARIABILITY

APPLICATIONS: 5033 and 5034

APPLICATION: 5033

Page 2 – Section 5 – Select Coverage

Platinum Series Products\Gold Series Products	Applicant's Plan selection
Optional Riders	Applicant's Riders selection
Death Benefit Option	Applicant's Death Benefit selection
Automatic Premium Loan Option	Available for Whole Life Products only

Page 8 – Conditional Receipt

Retention Limit	$500,000.00

APPLICATION: 5034

Page 1 – Section 1 – Select Coverage

Face Amount Limit	Not to exceed $75,000.00
Gold Series\Platinum Series Products	Applicant's Plan selection
Optional Riders	Applicant's Riders selection
Death Benefit Option	Applicant's Death Benefit selection
Automatic Premium Loan Option	Available for Whole Life Products only

Page 6 – Conditional Receipt

Retention Limit	$75,000.00